TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-20-1278-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 21, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states the reimbursement calculation use for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $3,461.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In addition as per Medicare (section 10.2.3), when certain pairs of J1 services or in certain cases J1 serve and an add-on code) are reported on the same claim, the bill is eligible for a complexity adjustment, which provides a single payment for the bill based on the rate of the next higher comprehensive APC within the same clinical family. We did take this into consideration and the provider was reimbursed the surgical code with the higher allowable amount."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17 – 18, 2019	Outpatient Hospital Services	$3,461.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
   - P12 – Payment is included in the allowance for another service/procedure

- 97 – Payment is included in the allowance for another service/procedure

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $3,461.12 for outpatient hospital services rendered on September 17 – 18, 2019. The insurance carrier reduced the disputed services based on workers compensation jurisdictional fee schedule.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

   The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged.

   28 TAC §134.403, (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent unless the health care provider requests separate reimbursement of implants.

   Review of the submitted medical bill found separate reimbursement of implants was not applicable. The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure codes 49653 and 49650 have a status indicator of J1. In this instance, Medicare payment policy requires the procedures to be ranked and only the highest ranked code receives reimbursement. The ranking of Code 49653 is 859. The ranking of Code 49650 is 883 (see https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1695-FC-2019-OPPS-FR-Addenda.zip , Addendum J.

     Based on ranking Code 49650 does not receive separate reimbursement.

   - Code 49653 is assigned APC 5361. The OPPS Addendum A rate is $4,595.85, multiplied by 60% for an unadjusted labor amount of $2,757.51, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $2,267.78. The non-labor portion is 40% of the APC rate, or $1,838.34. The sum of the labor and non-labor portions is $4,106.12. The Medicare facility specific amount of $4,106.12 is multiplied by 200% for a MAR of $8,212.24.

2. The total recommended reimbursement for the disputed services is $8,212.24. The insurance carrier paid $9,191.70. Additional payment is not recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

	Peggy Miller	February 12, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.